ReforMedicine SC
Direct Pay Family Practice

New Patient Registration

PLEASE PRINT AND COMPLETE IN FULL

Patient's Legal Name:____
First **Middle** **Last**

Birthdate: ______________ **Gender:** Male________ Female_________
MM/DD/YYYY

Patient's Social Security Number:_______________

Patient's Street Address:____

____
City State Zip

Home Phone Number: ____-____-______ **Cell Phone Number:** ____-____-______

Work Phone Number:____-____-______ **Email Address:** ______________________________
Ext: _______ (patient portal access)

Parent/Guardian Name (if under 18):______________________________

Emergency Contact Name:______________________________**Phone Number:**________________

Relation to Patient:____

Do you have any allergies? Please list:____

Preferred Pharmacy:____

Medications/supplements

Name	Dose	Directions

______**If you have additional medications please check here and continue the list on the back of the page.**

*Cash and check payments receive a $5.00 discount!
If you are a *Direct Primary Care* patient the discount does not apply to you.
Please let staff know if you are on Medicare, Medicaid or Badger Care. Thank you.